

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>002392</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>02/24/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>TERRACE AT TOWNE CENTRE, THE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7252 ARTHUR BOULEVARD</b> <b>MERRILLVILLE, IN 46410</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a post survey revisit (PSR) to the State Residential Licensure survey completed on 01/19/11.</p> <p>Survey dates: February 24, 2011</p> <p>Facility number: 002392 Provider number: 002392 Aim number: N/A</p> <p>Survey team: Regina Sanders, RN TC Kelly Sizemore, RN Sheila Sizemore, RN</p> <p>Census bed type: Residential: 47 Total: 47</p> <p>Census payor type: Other: 47 Total: 47</p> <p>Sample: 3</p> <p>The Terrace at Town Centre was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the State Residential Licensure Survey.</p> <p>Quality review completed 2-24-11 Cathy Emswiller RN</p>	{R 000}			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE